About the BMA
The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Most BMA members are members of the NHS Pension Schemes. This is a response from the BMA to the *NHS Pension Scheme: pension flexibility* consultation document, published 11 September 2019.

Will the suggestions made in the consultation document solve the problem?
The consultation document does not convey the full extent of the impact of pension taxation on doctors within the NHS. In particular it underestimates the significant issues that result from the interaction between the 1995/2008 final salary schemes and the 2015 scheme that was imposed. The reality is that due to this interaction and the revaluation of the accrued 2015 Pension, most doctors with a taxable income of over £110,000 will be affected by the annual allowance.

Given the complexities, The BMA does not consider it possible for the perverse implications of pensions taxation legislation to be resolved within a pension scheme. Therefore, any flexibilities introduced after this consultation – even if they are the most appropriate and creative flexibilities possible – will provide little more than a sticking plaster to cover the issue.

We are extremely disappointed that the consultation does not include a specific proposal for the mandatory recycling of employer’s pension contributions. These employer’s pension contributions form a vital part of a doctor’s total reward package and therefore without this, the flexibilities outlined are a significant reduction in the overall value of BMA members’ pay. This is highly regrettable, not least because it would be cost neutral to the employer and without the inclusion of recycling, the perverse incentive for doctors to reduce the work they do for the NHS will remain.

The BMA believe that the recycling of employer’s contributions should be built into the NHS pension scheme itself in order to ensure this is not only equitable across both primary and secondary care but is not administratively burdensome for employers. Under such a proposal, employers would pay the full amount of employers pension contributions to the NHS pension scheme regardless of the percentage the employee elected to accrue (e.g.30:30) and at the end of the financial year any unused employers pension contributions can be used to top up the accrual level or recycled back to the employee.

Should the pension flexibility proposal not be modified to include full and mandated recycling, the BMA would have no choice but to continue to advise its members that the flexibilities represent a substantial cut to their total remuneration package.

BMA members have devoted their lives to caring for patients in the NHS but are being forced to reduce their work commitments — against their wishes — by a perverse pensions taxation legislation which imposes huge annual tax bills for a benefit that they won’t receive, often for decades, and in many cases means that they are effectively paying to go to work.

This cannot be right and must change immediately.

By email to: NHSPSconsultations@dhsc.gov.uk
The BMA’s approach to date
The BMA has consistently called for an end to the Annual Allowance (AA) and the Tapered Annual Allowance (TAA) in the NHS pension scheme (NHSPS) and other defined benefit public sector pension schemes and will continue to do so until these calls are heeded.

The BMA has written to and/or met with the Prime Minister, The Chancellor, The Treasury, Department of Health and Social Care and several MPs on multiple occasions, asking to enter in to a meaningful dialogue to address this very serious issue and the harm that it is currently inflicting on patients.

The warnings that we issued are now being shown to be true; every day articles appear in the media detailing the impact that the perverse pensions taxation legislation is having on the NHS and its patients.

A year ago, we suggested that given that it is overwhelmingly doctors who are affected by the perverse implications of pensions taxation legislation, we should work with DHSC, NHS Employers and HMT to find a solution.

The response from government was that the appropriate forum for discussion was the NHS pension Scheme Advisory Board (SAB). Shortly after this work began at SAB we were told that the separate consultation would carry greater weight than the SAB discussions.

In any event, the SAB discussions were never likely to deliver any meaningful outcome, given the government’s insistence that the remedy to the perverse implications of pensions taxation legislation be conflated with the issue of lower paid NHS employees opting out of the scheme. These are separate, and very serious issues that need to be looked at properly however, they are not inter-linked.

Introduction section of the consultation document
The BMA has never proposed 50:50. This suggestion is repeated several times in the consultation document and is both misleading and unhelpful.

As we have consistently pointed out, 50:50 was never the answer to the potentially catastrophic issue of doctors reducing their workload in the NHS due to the perverse implications of pensions taxation legislation.

We are pleased to note that the government eventually acted on our concerns and withdrew the previous consultation document.

Specific questions

1. Who do you think pension flexibility should be available to?
   Pensions flexibility should be targeted at any member who is affected by the perverse implications of pensions taxation legislation. That will include senior nurses, dentists, NHS managers and others. To exclude certain professions from this is, in our opinion divisive and unhelpful. Any solution should be available to all groups affected by these punitive taxes.

   There has been an attempt at SAB to conflate the tax issues faced by higher earners in the NHSPS with those of lower earners, amongst whom opt outs are high due to the cost of the scheme. We believe that the two issues are separate, and that the government should undertake separate work on why lower paid members opt out in such high numbers.

   Crucially, those NHS workers who need to utilise flexibility are not receiving an enhanced benefit, even if recycling of employer’s pension contributions are offered. The pension flexibility is being offered to prevent those members from the detrimental and ill-conceived system of pension taxation that currently exists.
2. Do you think the proposal for a more tailored approach to pension accrual is flexible enough for senior clinicians to balance their income, pension growth and tax liability?

No. These pension flexibilities are a much needed but temporary mitigation. In meetings with representatives from DHSC and the Treasury, it was clear that the detrimental effects of the changes to pension taxation and in particular the tapered annual allowance were not known at the time they were introduced. The effect of these taxes is having a catastrophic impact on patients and the NHS as doctors are forced to stop doing overtime because by doing so they are essentially paying to go to work. Moreover, doctors and others are currently disincentivised from aspiring to excellence and promotional opportunities where these could result in taxes that are far greater than the value of any pay rise—which may in any event be temporary. We have widespread reports that there are insufficient applicants for Clinical Excellence Awards, despite these being contractual and doctors are giving up or declining to take on managerial or educational responsibilities. The long-term solution to this problem must lie with reform of pension taxation including the urgent scrapping of the tapered annual allowance.

In addition, the proposals are too complex for members to manage and without mandatory recycling of the employer’s pension contributions, represent a significant pay cut.

3. If not, in what ways could the proposals be developed further?

The perverse implications of the current pensions taxation legislation can only be addressed by changes to the pension tax system. The tapered annual allowance must be removed immediately. We believe that there must be a fairer, more transparent way to raise revenue from pensions taxation and we have consistently said that we would be happy to be a part of that conversation. In addition, we believe that annual allowance is fundamentally unsuited to defined benefit schemes where growth cannot be easily controlled. Furthermore “deemed” pension growth may not be a true reflection of ultimate pension, for example due to unknown retirement ages and temporary pay rises. In addition, the cost of “tax relief” is overstated. In the NHS pension scheme, higher earners already pay significantly higher pension contributions (up to 14.5%) than lower paid members (as low as 5%) despite the vast majority of members now being in a CARE pension scheme. These higher contribution rates were justified on the basis of reducing higher rate tax relief. In addition, as outlined in the document, income tax is still paid once the pension is received. In addition, tax relief is already limited by the lifetime allowance. However, it must be noted that since this has also been reduced, this has become a powerful driver to push doctors towards early retirement. Consequently, there are now multiple approaches to limiting tax relief (tiered contributions, tapered annual allowance, standard annual allowance and the lifetime allowance) which, when combined, are disproportionate and unfair.

As we have stated above, it is essential that the proposals are accompanied by the recycling of the unused element of the employer contribution back to the member as taxable income. Anything less amounts to a pay cut and a significant loss of the total reward package offered by the NHS. As outlined above it is essential that mandated recycling is included in the proposals and ideally built into the NHS pension scheme.

Trusts save large amounts of money; money from employees who have opted out of the NHS pension scheme, money that would formerly have been spent on employer pension contributions. Those savings have been used by trusts to support their bottom line at the expense of those employees for whom the spending was originally intended.

This is an issue that must be addressed if these flexibilities are to have any effect. We firmly believe that the only realistic prospect of this occurring in a uniform and equitable way is if this is mandated centrally or at pension scheme level.

4. We’re proposing that large pay increases for high-earning staff should only be included in their pensionable income gradually. Do you agree or disagree with this proposal?

We agree that it would help to manage spikes in pay which can cause large annual allowance charges. However, it is complex and the communications to members around the issue would be highly challenging. In any event, unless pay increase phasing is accompanied by the recycling of the unused element of the employer contribution back to the member as taxable income it will amount to a pay cut and a significant loss of the total reward package offered by the NHS. In
addition to recycling of lost employer contributions, it is essential that any phasing of payments has a balancing payment to the employee to ensure that they are not penalised by the delayed pay award — this is cost neutral to both the employer and employee — as if the pay award had been given in full when it was due.

We firmly believe that any such phasing of large pay increases should be optional, and the employee should be able to decide if they wish it to be phased, based on their individual circumstances.

At present the value of pension growth over the scheme year (the pension input amount, or PIA) is calculated separately in the 2015 Scheme and 1995/2008 Schemes. This is hugely unfair as it gives members no transfer of unused AA between the schemes. Allowing such a transfer of unused AA is likely to negate the need for a complex system of pay increase phasing.

5. **Currently, the NHS Pension Scheme has a notional defined contribution pot (NDC) approach to Scheme Pays deductions. We’re proposing to replace this with the debit method. Do you agree or disagree with this?**

Whilst we do not think that there should be a move away from the NDC approach, scheme pays is charged at an exorbitant rate which can lead to doctors running up seven-figure scheme pays debts.

We note that pension debit method is already operational for doctors in the Scottish NHS pension scheme and we have no evidence that they find this approach any more transparent than the NDC approach. Furthermore, we also note from the worked examples that the pension debit is currently more expensive to the employee than the NDC approach and we would object to any change to the scheme pays methodology that makes it even more expensive.

6. **What impact, if any, do you think the proposals will have on people with one or more protected characteristics?**

   We are not aware of any such impact.

7. **Are there any further equality considerations that the Department should be aware of from groups outside the data set?**

   We are not aware of any such groups.

**General comments**

The Annual Allowance (AA) and Tapered Annual Allowance (TAA) are beyond the comprehension of most experienced accountants, tax advisers and IFAs. The cohort of people who fully understand the legislation is tiny.

Whilst the BMA has provided a huge amount of information about AA/TAA it is still by far and away the most common query that the BMA pensions department receives.

The BMA has provided members with access to *The BMA Goldstone Pensions Modeller*. However, even with this powerful tool at their disposal, members need to undertake a huge amount of reading, gather together the relevant paperwork and then spend around four hours modelling their own situation.

AA and TAA need to be removed immediately from DB schemes and be replaced by a fairer alternative, one that members can readily comprehend, in the same way as they can comprehend other taxes such as income tax.

The provision of information from the NHS Business Services Authority is very poor. This appears to be because they are massively under resourced in trying to administer the fourth largest occupational pension scheme in the world.

We would like to see the following improvements to assist members in the administration of their AA/TAA liabilities:
– All Total Reward Statements (TRS) should have a prominent warning that the pension value displayed for the 1995 section for those who have purchased added years is not accurate,
– A letter to all affected 1995 section members with added years setting out the problem of inaccurate TRS and pension saving statement (PSS),
– An independent inquiry into the accuracy of pension saving statements for those members with 1995 section pension benefits who have purchased added years,
– Any member subject to a retrospective AA bill due to the scheme’s failure to provide accurate added years data should be able to pay the charge using scheme pays, even if the deadline has passed for the relevant tax year,
– The election for scheme pays deadline of 6 months should start when the member receives the PSS from NHS BSA and not the end of the tax year,
– Annual PSS, giving growth of pension for the last 7 years, should be available as part of TRS and accessible electronically within 4 months of the end of the financial year,
– As an interim measure, whilst online pension saving statements are developed, all NHSPS members with pensionable pay in excess of £50,000 should automatically receive a paper PSS, whether they have breached the AA limit based on NHS pension or not,
– The new TRS and PSS should contain a downloadable table of input data to enable members to check their PSS. We would like to see consultation with members on the scale of information included to ensure it meets their needs,
– Previous versions of TRS and PSS should be available online, not just the current version,
– TRS should include consideration of additional pension and ERRBO purchases,
– There is an urgent need to address the delays in information being provided to GPs as well as the inaccuracies and delays caused by the poor performance of Capita and PCSE which must be resolved. We have raised these issues several times on behalf of members, but we have seen no improvement.

**Annualising**

The BMA continues to be opposed to annualising. Annualising only applies to GPs in the 2015 scheme and it discriminates particularly against GP locums, who as a group are less likely to be in the scheme for a full year. Many GP locums are from groups who have legally protected characteristics (ethnic minorities, women, and those with disabilities) and who are more likely to take breaks. Furthermore, the factor of 365 is wholly inappropriate.

For these reasons, we consider that for as long as the practice of annualising remains, the 3-month concession rule for exclusive GP locums must be restored to help reduce this group from being disproportionately negatively affected by annualising.